

Social Security Number:

Last Name:

First Name: M.I.

Nick Name: Sex: F M Age: Date of Birth:

Address: _____

Zip: _____ City: _____ State: _____

Driver License Number: _____

Email Address: _____

Note: Primary, Secondary and Cell phone numbers are used by this office to contact and/or to leave messages.

Primary Phone: - - Ext:

Is this number: Home Work Cell other: _____

Secondary Phone: - - Ext:

Is this number: Home Work Cell other _____

Other Phone: - - Ext:

Is this number: Home Work Cell other _____

If minor, list guardian (parent): _____

Address: _____

Zip: _____ City: _____ State: _____

Home Phone: _____

Name of primary physician involved in your care:

Last Name: _____ First: _____

Address: _____

City: _____ State: _____ Phone: _____

Marital Status: Single Married Divorced Widowed Other

Alternative contact name (Not Spouse) _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: _____

To whom may we release information?

Spouse Patient Your Voice Mail Other

Patient's employer: _____

Address: _____

Zip: _____ City: _____

State: _____ Phone: _____

Spouse employer: _____

Address: _____

MD Requesting Consultation: _____ (First name) _____ (Last name)

Address: _____

- Rama Jager, MD, PhD
- Shekar Narayanan, MD
- Arun Gowdamarajan, MD
- Ateet Shah, MD

Primary Insurance Subscriber:

Self Spouse Parent Other

Note: If other than patient, please complete every line, or we may be unable to file claims with your insurance for you

Insurance Co. Name: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (If other than self): _____

Sex: F M Date of Birth: _____

Subscriber's Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscribers Employer: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy #: _____

Group #: _____

Plan #: _____

Secondary Insurance Co. Name: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (if other than self): _____

Sex F M Date of Birth: _____

Subscribers Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscriber's employer: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy#: _____

Group# _____

Plan #: _____

Do you have a third insurance company? Yes/No

Company Name: _____

How did you hear about us? Doctor Friend/Relative

Yellow Pages Insurance Provider Book Billboard Other

Insurance: As a courtesy to me, my care will be billed to my insurance carrier and remain my responsibility. I agree to forward all insurance payments to this office. I authorize release of medical information necessary to process claim and authorize payment of medical benefits to my physician.

Billing: Interest will be charged on all outstanding patient balance after 30 days. If after reasonable notice of any balance due on my account, payment is not made, I will be responsible for collection attorney and court costs.

Interest: I understand that my physician may have an ownership or investment interest in Surgery Center Plus, an outpatient surgery center. I acknowledge that any questions I may have regarding such interest will be explained and discussed with me in substance in order to concur knowledgeably, within reason, in accepting his referral for treatment. Further, I understand that I may choose to be referred to another health care entity without consequence.

Privacy and Security: I acknowledge that I have received the Center Plus Privacy Notice and Red Flags Rule.

Signature: _____ **Date:** _____

HEALTH HISTORY DATA SHEET

Current Health

Height: _____ Weight: _____ Per CRC scale
 B/P: _____ Pulse: _____

What prompted this visit? _____

Primary MD: _____ Cardiologist: _____

MD requesting consultation: _____

New health problems or surgeries since your last visit: _____

Yes No History of Present Illness

- Blood with Bowel movement
- Enough blood to turn toilet water red
- Rectal irritation and itching
- Hemorrhoidal bleeding
- Hemorrhoidal swelling
- Rectal Pain
- Constipation
- Black tarry stools
- Loose or Frequent Stools
- Abdominal pain, bloating, cramping
- Stomach pain after eating
- Nausea, vomiting
- Difficulty swallowing
- Heartburn/indigestion
- Other symptoms: _____
- Allergy to egg or soy
- Allergy to Latex

Name/dose/frequency taken None

Drug allergies		<input type="checkbox"/>
Narcotics used last 10 years		<input type="checkbox"/>
Current Medications	_____ _____ _____	<input type="checkbox"/>
Over the counter medications		<input type="checkbox"/>

Current Medical Problems None

Constitution:	<input type="checkbox"/> Lack of appetite <input type="checkbox"/> Chills/Fever <input type="checkbox"/> Weight loss	<input type="checkbox"/>
Eyes:	<input type="checkbox"/> Vision changes	<input type="checkbox"/>
Lungs:	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Active TB	<input type="checkbox"/>
Heart :	<input type="checkbox"/> Chest pain on exertion	<input type="checkbox"/>
Stomach:	<input type="checkbox"/> Spitting up blood	<input type="checkbox"/>
Blood:	<input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Anemia	<input type="checkbox"/>
Urinary:	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Hesitancy <input type="checkbox"/> Painful urination <input type="checkbox"/> Incontinence	<input type="checkbox"/>
Muscle/skeletal:	<input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain	<input type="checkbox"/>
Skin:	<input type="checkbox"/> Skin rash/hives	<input type="checkbox"/>

This information is true and correct to the best of my belief

Patient/Guardian Signature _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Annual Health Review

Yes No

- Stroke, Date: _____
- Seizures: Date diagnosed: _____
- Emphysema: Oxygen dependent? Yes No
- COPD Oxygen dependent? Yes No
- Sleep Apnea
- Asthma
- Angina Use Nitroglycerin? Yes No
- Heart Murmur: Need antibiotics@ dentist? Yes No
- Heart attack, Date _____
- Pace Maker: Date placed: _____
- Irregular heart beat
- High blood pressure
- Replaced heart valve: Date: _____
- Rheumatic Heart Fever/Previous endocarditis Date: _____
- Arterial Grafts or stents: Date placed: _____
- Mitral Valve Prolapse/ Congenital heart defect
- History of inflammatory bowel disease(Crohn's, colitis etc)
- Cancer location: _____
- HIV positive
- Anemia
- Diabetes, (diet controlled or medication)
- Kidney disease: _____
- Prostate problems: _____
- Liver disease: _____
- Implants or Artificial Joints: Where: _____
- Skin disease: _____
- Other medical problems: _____

Surgery History

Yes No

- Hemorrhoidectomy When: _____
- Appendectomy
- Stomach operation
- Gallbladder operation
- Spleen removed
- Colon operation When: _____
- Hysterectomy
- Heart Surgery: Type: _____
- Colon polyp/ When _____
- Colonoscopy: when /by whom: _____

List other surgeries: _____

Social and Family History

Yes No

- Do you drink alcohol? Social Moderate Heavy
- Do you smoke? Packs per day _____ #years _____
- Have you ever used recreational drugs? Type: _____
- Do you have any disabilities? List: _____
- Family with cancer? Who: _____ Type: _____
- Family with polyps? Who: _____
- Mother Alive: Cause of death: _____
- Father: Alive: Cause of death: _____

Occupation: _____

Center use only

Updated: _____